# reviews

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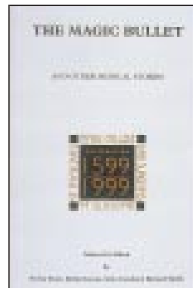
## The Magic Bullet and Other Medical Stories

Eds Stefan Slater, Robin Downie, Giles Gordon, Richard Smith



Royal College of Physicians and Surgeons of Glasgow, £6, pp 101
ISBN 0 953 5833 09
Books available from the college

Rating: ★★★

In medicine today, culture is "in," culture is sexy. The *British Journal of General Practice* includes new poetry and articles on doctors in literature. Last year's spring symposium of the Royal College of General Practitioners was on the theme of "The Art and Science of General Practice." Narrative based medicine, which suggests (to me anyway) the primacy of the patient's story as the starting point for the doctor-patient relationship, is now acknowledged as a necessary counterpoint to evidence based medicine, which often starts with the diagnosis of disease. Patients' stories are not fiction, but they are always interpretative, one of the qualities of fiction and literature.

This interest extends not just to literature but to all of contemporary culture. A recent copy of the *Lancet* contains an interview with a New York artist, Fred Tomaselli, who uses drugs and other pharmaceutical items in his collages. At conferences, distinguished doctors give lectures named after other distinguished doctors and use art and literature, past and present, to set medicine in the context of life today. In April, among the celebrations to mark the 400th anniversary of the Royal College of Physicians and Surgeons of Glasgow, the college held a two day conference on "Medicine and Literature." The meeting was fully subscribed and, by all accounts, highly entertaining and stimulating. In addition, the organisers put out a call for short stories from doctors and medical students, and published them as *The Magic Bullet and Other Medical Stories*. Ten years ago, I do not think that this would have happened.

These are all examples of the paradigm shift from pseudoscientific certainty to post-normal science, which acknowledges that all scientifically derived knowledge is provisional and must be balanced in decision making with other valid views of the world. The full implications of this shift for the doctor-patient relationship are still unfolding, and many patients and doctors find the new uncertainties of medicine difficult and unsettling.

Creativity in the consultation, in research, and in writing is the answer—perhaps, in the end, the only human answer. This volume of 16 stories illustrates this. They show a huge variety of styles and influences from Asimov to Garcia Marquez. Some are too sentimental for my taste, and some are descriptions, not stories. However, they show humanity, empathy with patients, and rage against the horror of disease and war. These are qualities that we need at the heart and the head of our profession.

**John Gillies** *general practitioner, Selkirk Medical Practice, Selkirk*

## Assuming the Risk: The Mavericks, the Lawyers, and the Whistleblowers Who Beat Big Tobacco

Michael Orey

Little Brown, £15.33, pp 352
ISBN 0 316 66489 8

Rating: ★★★

To anyone but the US audience for whom this book is intended, the defeat of "Big Tobacco" heralded in the book's title has yet to materialise. Thus, while the US tobacco industry settled the mammoth tobacco suits lodged by the 50 US states, elsewhere in the world the tobacco giants continue their denials and questionable marketing practices—seemingly oblivious. From this perspective, the events described in Michael Orey's book seem more like a minor skirmish on the edge of the tobacco control movement than a victory for the combined forces of governments and the public health community. Keeping in mind this minor quibble, *Assuming the Risk* is a tremendously readable and interesting book. Like the fictional novels of John Grisham, it is the characters who drive much of the book's plot.

As with most events that change the course of a movement, the US Master Settlement Agreement truly began years earlier in a small and poor county of the poorest state in the United States. Thus, starting with the Willie Horton case—which would serve as the linchpin and common reference point for the proceedings that followed—readers are led through the many cases and events that would culminate, years later, with Mississippi's decision to file suit against the US tobacco industry, a move subsequently followed, probably most notably by Minnesota, by the remaining 49 states. As Orey proceeds with his discussion, readers are introduced to a growing cast of characters, their every personality quirk and foible apparently disclosed by the author. Thus we are told of Merrill Williams' quasi-neurotic tantrums, Jeffery Wigand's difficult temperament, and Mike Moore's career-long determination to do good, as well as many other thumbnail portraits.

Where Orey leaves readers wanting is in not discussing the merits of the US states' litigation-driven strategy. Is the $246bn Master Settlement Agreement really a victory for public health? People are now questioning whether any deal made with the tobacco industry can ever be consistent with the interests of public health. While discussing the role of Congress in legislating the first multi-state agreement, Orey never addresses the apparent lack of coherence exhibited by US politicians on the issue of tobacco control. After reading this book, you get the feeling that the US public and politicians feel that no further legislative or regulatory action is necessary now that the tobacco industry has been forced to pay.

Perhaps one cannot fault Orey for sticking to what he does best, which is describing the situations, the people, and the manoeuvring that lead to US tobacco's first major setback. Written in a journalistic style that eschews legal jargon in favour of plain language, this book will be of most interest to those outside the legal profession. If not a must read, at least a good read.

**Michael A O'Neill** *sessional lecturer, department of political science, University of Ottawa, Canada*

## ADAM Interactive Anatomy

ADAM Software

Harcourt Brace, £1091.49
ISBN 1 572 45099 1

## The Anatomy Project

Debra Hastings-Nield

Parthenon Publishing, each CD £79.90
(free demonstration CD)
ISBN 185070 9106

Rating: ★★ ★★★

The teaching of anatomy is undergoing something of a revolution. Increasing numbers of medical schools are giving up traditional methods, such as dissection, in favour of student directed or problem based learning. Students are given access to computers as a major source of information, and are given multimedia packages when once they would have been given a cadaver and a scalpel. There is also a heavy demand for anatomical multimedia from postgraduates. This is fuelled partly by a shift in the surgical fellowship exams and a heavy reliance on distance learning, but also by a reduction in anatomy teaching in the undergraduate curriculum. The market for anatomical CD Roms is therefore booming.

*ADAM Interactive Anatomy* provides a "dissectable" man and woman and allows the user to move through a number of body "layers." Over 20 000 anatomical structures can be revealed, all of which can be identified by a click of the mouse. This provides a very pleasing result, albeit an artistic representation of the body rather than the real thing. However, structures move through and between anatomical layers, and this can make them difficult to follow.

One can also switch into other modes. In "Atlas Mode," pins are stuck into the structures, reminiscent of the old spotter exams. "3D Atlas" is limited, having only a few rotatable organs—such as heart, lungs, and skull. The "Slide Shows" are a useful feature for teachers, allowing the user to write text to guide students around the images.

The quality of the program and the considerable attention that has been paid to ease of use are commendable. However, it is essentially nothing more than a sophisticated atlas. It cannot teach anatomy, because anatomy is not just about learning the names of structures or knowing their position. It lacks textual information about the importance of structures or the context of their position in the body.

*The Anatomy Project* is entirely different. It is a series of 20 CDs covering both regional and systematic anatomy. They did not load easily; each, by default, was installed onto a separate folder on the hard disk and took 4 Mb of disk space. This caused duplication of files and took up more disk space than was necessary. Once I had overcome the initial difficulties, the program seemed to be well constructed and easy to use. The user is first presented with a menu allowing the selection of an appropriate level—nursing, medical, postgraduate, etc. Generally, I found the amount of detail excessive for all levels. For example, in the chapter on extrinsic muscles of the hand, there were 27 pages of text for postgraduates and 26 for medical students. I thought the level presented for nurses (16 pages) was sufficient for today's medical student.

The quality of the tutorials is exceptional, but users are presented with long video sequences containing detail that comes fast and furious. The information could probably be reduced to more easily digestible pieces, as in the "Summary" section. As it stands, the video tutorials would perplex and confuse most medical students. They would be better presented on video and, indeed, are available in that format.

Interactivity is provided in the "Atlas" section, which presents numbered structures whose names are revealed on the click of the mouse button. The "Quiz" section uses a "true or false?" format, and there is a useful review of information should the user get the wrong answer.

Overall, I was impressed by the quality of these products, but I do not think that either can replace more traditional methods of learning anatomy: a good textbook and atlas or a cadaver. I look forward to the new breed of multimedia packages that will bring closer appreciation of the relations between structure, function, and relevance to clinical practice.

**Alistair Hunter** *lecturer in anatomy, cell, and human biology, King's College London*

*Reviews are rated on a 4 star scale (4=excellent)*

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## NETLINES

- An interesting and a potentially useful service for doctors hoping to get papers published can be found at **www.publist.com/indexes/health.html**. This lists publications (both conventional print and online publications) and provides data about the names of the journals, editors, contact details, etc. Just over 15 000 medical titles are listed, conveniently divided into specialties, and there is an in-house search engine. Of course, you are not restricted to medicine in this site: altogether there are 150 000 publications catalogued, which can be accessed through the home page, www.publist.com.

- In medicine we face a constant struggle to cope with the seemingly endless combinations of letters that make up acronyms. Medical education is no exception, and a collection is published at **www.nottingham.ac.uk/~brzaf/Acronym.htm**. It is a simple listing but is both educational and amusing. If you don't know what ZBB stands for then this is a "must visit" website.

- Health informatics is a burgeoning specialty, and it is no great surprise that the internet is dotted with resources. One electronic journal covering this area is *Informatics Review* (**www.informatics- review.com**), which is a clever mixture of ever present material coupled with up to date reviews refreshed on a regular basis. It can be useful for both new and experienced observers of health informatics and is mainly text only. This at least means there are no large graphics taking an age to download.

- A good medical portal is always worth a browse and, if you like it, giving it the ultimate accolade by bookmarking it. One potential candidate can be found at **www.medic8.com**, which has plenty to offer both UK and international surfers. One plus is that you don't have to register with passwords that you will soon forget. It has a good collection of resources, which are catalogued into sensible and easy to find sections. It is a good launch pad to other sites, particularly for new net users wanting to find their way about.

- Being such a visual subject, radiology is well suited to the web: for a good example of what you can do with a computed tomogram visit "CT is us" (**www.ctisus.org**). The site contains a lot of material, and a good place to start exploring is from the site index. The images are clearly defined on the computer screen, and, of course, there is a journal club (kept well up to date), which is always going to be popular. As it stands it is an excellent site, but there is tremendous potential to include more images and data.

**Harry Brown** *general practitioner, Leeds*
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We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email

# The stigma of schizophrenia

When four psychiatrists published a study showing that six out of 23 schizophrenic patients carried weapons during psychotic episodes, little did they realise how their work would be presented to the public. The day after it appeared in the Royal College of Psychiatrists' *Bulletin* in 1998, banner headlines in the *Sunday Express* proclaimed: "Armed and dangerous: public at risk as mental patients escape the care net." The *Sunday Express* journalist extrapolated that 1250 mentally ill patients in the community carried weapons and posed "a serious threat to public safety." This claim was based on a figure quoted by the Zito Trust that 5000 schizophrenic patients in the community represented a danger to themselves or others.

Distortions of this kind are no surprise to mental health groups. Focus on Mental Health, an umbrella organisation, thinks that mentally ill people get a raw deal from the press, with words such as "maniac," "schizo," and "psycho" contributing to the stigma. Consequently, a year ago, it joined with the National Union of Journalists, the Department of Health, and Lilly Psychiatry to set up the Media Forum on Mental Health to fight inaccurate and unbalanced media coverage.

The mental health charity Mind is also trying to fight unfair reporting. It recently conducted a survey of more than 500 people within Mind's user networks to discover what impact media coverage of mental health issues had on their lives. Almost three quarters of respondents thought that media coverage had been unfair, unbalanced, or very negative. Moreover, half said that this media coverage had had a negative effect on their mental health, with a third feeling more anxious or depressed as a result and 22% feeling more withdrawn. Respondents voted the *Sun* as the newspaper with the worst coverage of mental health issues.

Journalists and mental health activists met at the Institute of Contemporary Arts in London, under the auspices of the Media Forum on Mental Health, last week to discuss this issue. In the "irresponsible media" corner were representatives from Carlton Television, Thames Radio, and the BBC, and journalists from the regional, national, and specialist press. The *Sun*, *Mirror* and *Daily Sport* were notable by their absence. In the "responsible, mental health service users and workers" corner were representatives from Mind, the Sainsbury Centre for Mental Health, the Manic Depression Fellowship, the National Schizophrenia Fellowship, and others. Health minister John Hutton also participated, and broadcaster Brian Hayes refereed the debate.

The main complaint from the mental health campaigners was that the media presented mentally ill people as dangerous time bombs waiting to explode, when the reality was quite different. They pointed out that 95% of homicides were committed by people with no mental illness and that mentally ill people were far more likely to harm themselves than others. Sue Baker, head of media relations at Mind, said: "Research published in January 1999 in the *British Journal of Psychiatry* showed that the proportion of homicides committed by people with mental illness has gone down by 3% a year since 1957. Yet this research was ignored by almost all the newspapers, with the exception of the *Guardian*."

I'LL SWEEP PSYCHOS OFF THE STREETS

Dobson to cage 'timebomb' fiends

EXCLUSIVE

One member of the audience pointed out that whenever an airplane crashed, killing everyone on board, a spokesman for the airline immediately appeared on the media saying how safe it was to fly and how exceptional were such accidents. But if a mentally ill person killed a member of the public there was no organisation whose job was to appear on television and explain how rare an occurrence that was too.

While media representatives did not attempt to justify the use of such words as "psychos" and "nutters" in media stories, they did try to explain why newspapers often gave massive coverage to instances when "care in the community" seemed to go wrong. Steve Hewlett, director of programmes at Carlton Television, explained that newspapers often made substantial mileage out of mental health incidents, such as the murder of Jonathan Zito by Christopher Clunis, because they knew it awakened fear in their readers. "It is always easier to reinforce your readers' views than challenge them," he said. "Newspaper editors are always trying to connect with their readers by showing that they understand them. It is easy for them to say: 'We understand your fears, we know that there are nutters with machetes out there. We are here to campaign to change things for your sake.'"

He suggested that the mental health service users and workers in the audience could adopt one of two approaches to change things. They could either try to appeal to newspaper editors' better sides, which was difficult and often not productive, or they could make sure that whenever a sensationalist mental health story was published, that they went through it carefully, picking out mistakes and reporting them either to the Press Complaints Commission or the Broadcasting Standards Authority. "The really trenchant, well thought out, well reasoned attack will get a response, if only from a newspaper or television company's competitor," Mr Hewlett added.

The debate saw little blood spilt. There were no knockout blows, mainly because the Mike Tysons of the media world—the *Sun*, *Mirror*, and *News of the World*—were not there. To see what the *Sun* thought about being named as the newspaper with the worst coverage of mental health issues, I telephoned David Yelland, the *Sun*'s editor, for a comment. His secretary said that she would see if he had anything to say. She never rang back.

**Annabel Ferriman** *news editor, BMJ*

WEBSITE OF THE WEEK

**Tropical medicine** Some giant leaps but mostly tardy progress is the message delivered by Murray and colleagues in this week's *BMJ* (p 490). Our understanding of tropical infections might have improved, but drug and vaccine development has been disappointing: the tsetse fly is a durable opponent, and Gambian sleeping sickness has risen sharply. African spending on health care is low, and public health measures are inadequate. Where to turn for help? The West, of course, or the web, which amounts to the same thing.

The American Society of Tropical Medicine and Hygiene (www.astmh.org/), the Tulane School of Public Health and Tropical Medicine (www.tropmed.tulane.edu/), and the Royal Society of Tropical Medicine and Hygiene (www.rstmh.org/) all are prominent web players. The Liverpool School of Tropical Medicine and Hygiene links to the Cochrane Infectious Diseases Review Group, and a practical section on treatment focuses on effective health care in developing countries (www.liv.ac.uk/lstm/ihd98-ehc.html#eu). For a rousing tour, however, the American Society of Tropical Medicine and Hygiene is hard to beat. Follow its clinical site links to the World Health Organisation's guide to vaccination requirements and health advice (www.who.int/ith/english/index.htm), as well as the CIA's "World factbook."

As for an African perspective, forget it. Thailand is as tropical as the web gets (www.mahidol.ac.th/mahidol/tm/h-tromed.htm).

**Kamran Abbasi**
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PERSONAL VIEW

# Why a massive tumour went undetected

I was 42 when my sacral chordoma was diagnosed. But an independent surgeon who reviewed my case found that the tumour should have been detected much earlier.

After nine months of lumbar pain I was referred for an *x* ray investigation, but the investigating radiologist reported that no abnormalities were found. The subsequent independent review, however, said that my radiographs "clearly" showed that the lower third of the sacrum was missing and that there was a "very obvious" mass arising from the terminal section of the missing sacrum, extending anteriorily and displacing the bowel.

The tumour remained undiagnosed for a further seven months, allowing it to grow well up the S2 vertebra, until it measured 10 cm in an anterior to posterior direction and 12 cm side to side. This necessitated an anterior and posterior approach to remove the lower half of my sacrum, including the S2 and S3 nerve roots, and a permanent colostomy. I now have to self catheterise about five times a day and suffer from hyperreflexia and bladder instability. I also have to live with an increased chance of recurrence: indeed, I have had four.

Why did this tumour go undetected for seven months? Firstly, the radiologist failed to look at all the original films. In a letter of apology the hospital wrote of the "failure on the part of the consultant radiologist to recognise a lesion of the sacrum which is clearly visible on one of the views taken. We fully accept that it is the duty of a radiologist to look at the whole film; this was a very unfortunate case of human error."

Secondly, perhaps because of the reassuring initial report, consultants and general practitioners failed to act on my developing symptoms. When I went back to my general practitioner with back pain and the new symptoms of burning pains to the genitals and frequency of urine, I was advised to wear boxer shorts. When I suffered two attacks of acute urine retention no other *x* rays were taken nor was there a second look at the original radiographs.

Worse still, while I was in hospital no consultant urologist or neurologist examined me, despite it being unusual for a 42 year old man to go into retention and despite my history of back pain. Unfortunately, the opportunity to palpate a mass that then extended 9 cm anteriorly was lost. I was superficially examined by a junior neurologist and was discharged without a diagnosis. When I reported ejaculation without orgasm, I was told to wait for a non-urgent, outpatient urodynamics test. Apart from a letter from the hospital to my general practitioner recording this, no serious notice was taken of my worsening symptoms.

The third reason was referred to in the independent report as the "significant problems in the radiology department." This covers the initial error and later events, when I went into retention a third time, lost the sensation of urination, and was doubly incontinent with diminished sensation in the genital region. The independent report found that the hospital missed the tumour again on a myelogram, which "clearly" showed the lower half of the sacrum to be missing, and also missed it on a magnetic resonance scan because the sacral area was not included, despite the "clear-cut clinical details" and a neurologist's request that the whole of the spine be filmed.

> This was a very unfortunate case of human error

The fourth reason, possibly the most serious, was the culture of disrespect towards patients in the hospital, shown by the inability of doctors and nurses to work together constructively; flippancy; and a neurologist writing me up in the notes as "a difficult, rambling, historian"—an unwise and highly insensitive description of a, by then, frightened and desperately ill patient. Even after the hospital's mistakes had been recognised, the chief executive and the doctors involved declined my offer, made through my lawyers, to meet me and learn from my experience.

The general practitioners in my health centre, however, were willing to learn. During my illness, I attended 12 times, on one occasion being stared at with wide eyed stupefaction after reporting numbness with incontinence. While recuperating from my operation, I instigated a meeting at my home and made the point that general practitioners should be patients' advocates and be prepared to query results of investigations and hospital discharge letters. The doctors argued that two of the hospital's discharge letters were "red herrings," which led them to believe that everything possible had been done for me, and that there was a "chain of command" extending downwards from consultants, which should not be broken.

But general practitioners are independent professionals, and, because the two discharge letters were headed "cause undiagnosed" and contained no mention of any specific investigations into my pain and mobility problems, there were ample grounds for asking the hospital to think again. After the meeting, the health centre wrote, "We will certainly do our best to learn from this experience and hopefully improve some attitudes and practices."

If I had to leave doctors with one message from my experience it would be to emphasise the importance of listening to the patient and querying reports of investigations and examinations when symptoms and signs do not match the results.

SOUNDINGS

# *Lord, protect me from my friends*

My partner and I don't socialise much together. It isn't that we dislike each other but rather because we don't feel the need. We have been watching each other's backs for so long now we can hardly remember what we look like from the front, and the bonds between us run much deeper than mere sex.

You can choose your friends, but you are stuck with your relations and, in the same way, having a partner is almost as good as having a real friend.

A relationship like this does not even need words anymore; we can be both supportive and adversarial (without offence) to each other as each case demands. On a practical level I can read his notes and he can read mine, no matter how hasty or ineligible; we also need to be able to follow the mental gymnastics behind the notes, no matter how subtle or cryptic.

There is still a place for sporting one upmanship. Making an obscure diagnosis is all very well but true tactical gratification comes from starting a kid with flu on antibiotics after my partner had seen him a few days before and given only good and academically impeccable advice.

> A relationship like this does not even need words anymore

By now, of course, the kid is getting better on his own, but the credit will go to me and my astutely prescribed antibiotics, and my local prestige will rise a notch.

Paediatric otitis media in particular is the medical equivalent of kicking for touch. It keeps the parents happy by giving them a definitive diagnosis and treatment, and no one can call you a liar; it requires an oroscope to view the inner ear and by the time anyone else has checked it, why, it's got better precisely because of the antibiotics you prescribed. Anyway my anecdotal experience is that viral illnesses do respond to antibiotics.

And if we don't do it, and we end up referring the kid, the hospital will start antibiotics as soon as he hits the doors, so it's better we screw each other than have the hospital screw both of us; it's always better that these unpleasant things are done by someone you know.

**Liam Farrell** *general practitioner, Crossmaglen, County Armagh*